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Protecting the Individual in Australian Health Law: Consent to Treatment and Medical Error and Patient Redress

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I. Introduction

Australia's health law operates at the intersection of legal doctrine, bioethical principles, and clinical medical practice. It draws on a core legislative framework, common law developments, and a regulatory

system, with the central goal of protecting recipients of healthcare services. This paper centres on two topics *Consent to Treatment (Topic 2)* and *Medical Error and Patient Redress (Topic 4)* to critically assess the level of individual rights and interests protection that this system delivers. It also analyses the logic through which the four foundational bioethical principles of autonomy, beneficence, non-maleficence, and justice activate the legal framework, as well as the potential tensions between these ethical principles and the legal system.

The analysis is as follows: Part II reviews laws related to treatment consent, covering the principle of informed consent, and the legal arrangements for individuals without decision-making capacity and children; Part III analyses the rules governing medical malpractice and patient remedies; Part IV evaluates the validity of bioethical principles; Section 5 summarizes the core conclusions of the full paper.

II. Consent to Treatment

A. The foundation principle and its Legal Expression

The importance of informed patient consent to treatment is recognized and accepted on an international level. The right of the individual to decide what is done, or not done, to his or her body is at the core of any discussion of consent. This right is based on the ethical principle of autonomy, which is reflected in the law of trespass to the person. At times, the overarching protection of autonomy can create a tension between it and other ethical principles, mainly the medical imperatives of beneficence (to do good) and non-maleficence (to do no harm). Autonomy may also run counter to the principle of sanctity of life. Such conflicts come mainly in the context of treatment refusal. However, as the law

clearly protects autonomy and the right to determine what happens to one's body, autonomy is given priority in the "hierarchy" of ethical principles[1].

The High Court in Australia in *Rogers v Whitaker (1992) 175 CLR 479* ruled that a surgeon who failed to advise a patient that he was a 1 in 14,000 risk of developing sympathetic ophthalmia after eye surgery was liable in negligence. The Court rejected the notion that the standard of care for informing patients of risks is based on the practice of other professionals (as under the Bolam test in England) and stated that the basis for the standard of care is that of a reasonable patient given the circumstances. This patient centred standard is a strong safeguard of patient autonomy, it places the patient above the professional paternalism, it gives the patient the right to be the one to decide what matters to them in a medical decision, and not the practitioner. After *Rogers v Whitaker*, it will be a practitioner's duty to communicate the material risks that a reasonable person in the patient's position would attach significance to, or risks that the practitioner knows or should know the particular patient would attach significance to. This dual formulation objective and subjective is a sincere attempt to customize the protection to the situation of the individual patient. The High Court made it clear that doctors should not be "gatekeepers" to information that patients require for independent decision-making[2].

But as s noted in *Marion's case*, the 'transformative use' aspect of the ' consent' renders what would otherwise be illegal action acceptable. The starting point is thus to reflect on what is illegal with respect to medical treatment without consent. The most frequent type of tort is the tort of trespass to the person. But consent to treatment may be the crime of assault as well. These will be discussed individually. There are three kinds of torts of trespass to the person: assault (unlikely to be relevant in relation to medical treatment); actual contact without consent (battery);

1 Benjamin Peter White et al, Health Law in Australia (4th ed., 2023). P 129
2 Rogers v Whitaker (1992) 175 CLR 479 at 490 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

and complete deprivation of liberty (for example, wrongful detention in a mental health facility without consent). It is with the tort of battery with which we are most concerned (the basic features of which are an "unprivileged and unconsented to invasion of one's bodily security")[3].

B. Consent, Capacity and Refusal of Treatment

Australian law acknowledges that consent must be freely given and must be made with "decision-making capacity" (DMC)which means being able to understand, retain, use and communicate information. When a patient has the capacity to make decisions, the law is clear: an irrational rejection of life-saving treatment must be respected[4]. In all cases, it is the right of every adult with DMC to make decisions that impact their life, regardless of the rational, irrational, unknown or nonexistent reasons. Under the common law doctrine, a patient with adequate DMC has the right to refuse medical care, even if this may lead to the end of his or her life. This fundamental principle of health law is the right to autonomy or right to self-determination, which is recognized by a number of international bodies[5]. Any religious, cultural or idiosyncratic personal beliefs that may be at odds with others are thus protected within this framework. As the authors note, although legal capacity and ethical autonomy are correlated, the law's binary structure of capacity or no capacity can be more protective or less protective of individual patients. Capacity to make decisions: Assesses an individual's legal capacity to agree to or decline procedures, investigations and interventions. The ability to make decisions has been suggested as the definition of DMC, but this simplistic view is argued against by the description of the arrival at this juncture as a complex and multivariate process, partly influenced by value and other social and idiosyncratic factors[6].

3 Secretary, Department of Health and Community Services (NT) v JWB (Marion's case) (1992) 175 CLR 218.

4 Scott Lamont, Cameron Stewart and Mary Chiarella, 'Decision-Making Capacity and Its Relationship to a Legally Valid Consent: Ethical, Legal and Professional…' (2016) 24(2) Journal of Law and Medicine 371.

5 White et al (CH 5) 133.

6 Lamont, Stewart and Chiarella (n 10) 376

Consent needs to be based on the wishes of the patient. These preferences can be shaped with the backing of family and health care providers, and actually can be shaped by such providers. This is a denial of the fact of human relationships and the importance of a patient's support network. However, the preferences stated cannot be used to override the will of the patient and care should be taken to ensure that support does not become undue influence[7]. If there is no capacity, there will be decision-making frameworks. These include guardian legislation and the parents patriae jurisdiction of courts. In Hunter and New England Area Health Service v A (2009) 74 NSWLR 88, the High Court of NSW (McDougall J) upheld a decision of a judge of the Supreme Court in Sydney granting a specific permit for a Jehovah's witness to refuse a blood transfusion, despite the fact that the refusal to accept the blood transfusion was made before the onset of the condition, which rendered him incapable of making the decision[8].

One of the most disturbing aspects of the Australian health law has been the forced sterilisation of people with disability, and the absence of safeguards against it. Existing policies on sterilisation need to be rethought and new legislation needs to be developed to ensure sterilisation is not dehumanising, but allows for the exercise of human rights; human power of choice and places the best interests of people with intellectual disability at the centre. The 2013 Senate enquiry into involuntary/coerced sterilisation of people with disabilities and intersex people revealed that there had been cases of sterilisation undertaken with the law's blessing via court authorisation[9].

C. Children and Consent to Medical Treatment

Generally, a child cannot be medically treated without their consent, or the consent of a person or court having authority to consent, as in the case of adults. To do so will constitute both a criminal. assault, and

7 White et al (CH 5) 138
8 Hunter and New England Area Health Service v A [2009] NSWSC 761
9 Senate Community Affairs Committee, 'The Involuntary or Coerced Sterilisation of People with Disabilities/Intersex People in Australia (Australian Parliament, 2013) Ch 2.'

trespass to the person. The common law and legislative regimes provide some exceptions to this principle which are designed to meet the requirements of the special and unusual cases. A doctor, for instance, at common law can treat a child in an emergency when the child cannot consent, and when the child's parent is not available to consent; and can also treat a child when the child's parent has abandoned him, and the child is not in the care of a person in "*loco parentis*". The general rule is that parents have the right to consent to treatment on behalf of their children but that this is not an absolute right[10].

Courts have the power to overrule parental decisions with regard to treatment if it is in the best interests of the child, under the parens patriae authority. A principle, known in Australia as “the Gillick competence” (*Gillick v West Norfolk and Wisbech Area Health Authority (1986) AC 112*), was developed in England, and says that young people who are sufficiently mature and able to understand and appreciate the nature and consequences of the proposed treatment can consent independently of their parents[11]. This is a significant safeguard for the growing independence of older children, acknowledging that 'adult/non-adult' is a false dichotomy in adolescents' development.

These principles have been put to the extreme test in the case of transgendered youth. The Family Court was asked in *Re Imogen (No 6) [2020] FamCA 761* whether a 16 year old was Gillick competent to make a decision to receive stage 2 hormone therapy for gender dysphoria, a decision that Bell J found the young person lacked Gillick competence for this specific treatment, a finding that has been widely decried as academically flawed[12]. Dimopoulos has said that the Court's reasoning is "a lack of understanding of the rights of children" and that the burden of special court authorisations for gender-affirming care is restrictive of vulnerable young people receiving health care[13].

10 White et al (CH 6) 152
11 White et al (CH 6) 154.
12 Re Imogen (No 6) [2020] FamCA 761 [1]–[5].
13 G Dimopoulos, ‘Rethinking Re Kelvin: A Children’s Rights Perspective on The ‘Greatest Advancement in Transgender Rights’ for all Australian Children’ (2021) 44(2)

These cases are examples of the conflicted nature of protection in health law. The need for court authorization was intended to safeguard the children, but in practice, this need can be harmful in terms of delay and/or access to treatment. Protection as a concept in the law can clash with lived needs of the people who it is supposed to protect, and this is an ongoing tension that manifests throughout both issues explored in this essay.

III. Medical Error and Patient Redress

A. The Governance of Patient Safety

Patient safety is governed in a fragmented manner in Australia, by the Commonwealth and State governments, professional regulatory bodies, health complaints commissioners and the courts. The National Health Reform Agreement established the Australian Commission on Safety and Quality in Health Care, which is responsible for national standards and accreditation of health services. These systemic mechanisms are a significant way of protecting patients, because they work before the event, not afterwards – when they are harmed by a medical mistake[14].

Civil liability laws have been introduced in each of the States and Territories, and they now regulate questions of whether the duty has been breached, whether that breach of duty was the cause of the damage suffered, defences and claims for damages, etc. although there are differences between jurisdictions in several respects. As a consequence, a health provider's liability in tort will now be determined in accordance with a mixture of common law and statute. The civil liability legislation,

University of New South Wales Law Journal 637.

14 Anne-Maree Farrell et al, Health Law : Frameworks and Context (Cambridge University Press, 2017). 101

however, was relatively new, and there were differences between jurisdictions, creating an uncertain situation in some jurisdictions where the common law and statutory law are in conflict. Statutory consumer guarantees which may be applicable to the provision of health services may have significant implications for consumer protection legislation change for health professionals[15].

B. The Law of Medical Negligence

There is a variety of legal remedies available to the patient who have been harmed based on contract, intentional torts, property and equity. However, there are limitations on those causes of action. So, for example, a patient could sue for breach of contract, although such an action is limited to the express terms of the doctor-patient contract (of which there are few), or breach of an implied term. Although a patient's claim that there was an implied term that the doctor promised to heal the patient, a court has been hesitant to impose such a term. Likewise, if a patient is operated on due to a physical intervention from a doctor without the patient's consent (such as an arm vs. a leg), that same concept of battery is not going to be much help. [16] In these situations, however, there is another cause of action which may be considered; namely an action in negligence. In medical negligence cases, the obligation of a health care provider to a patient is usually not the issue that is most contentious, rather it is the issues of breach of duty and causation.

15 White et al, (CH 8) 257

16 Anne-Maree Farrell et al, Health Law : Frameworks and Context (Cambridge University Press, 2017). 139

It has been accepted in Australia that the level of care which a person with any special skill or competence is expected to follow, is for a person who has that special skill and professes that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. The *Bolam principle* is not always observed, even in the most core of skilled medical practice, diagnosis and treatment. But the Bolam principle has been abandoned, to be replaced by the principle that, whilst the standard of acceptable medical practice is a useful guide for the courts, it is for them to determine what is the appropriate standard of care, bearing in mind that "the paramount consideration that a person is entitled to make his own decisions about his life"[17].

Although the common law rules governing Australia's tort of negligence have been in operation for many years, in 2002 all jurisdictions across the country introduced civil liability legislation based on the recommendations of the *Ipp Report*, partially reinstating the peer practice standard for specific categories of conduct. Section 5O of the New South Wales *Civil Liability Act 2002* and equivalent provisions in all other states explicitly stipulate that a practitioner who acts in line with widely accepted professional peer opinions will not be found negligent, unless the opinion itself is unreasonable[18]. McDonald criticizes this reform for completely reversing the policy balance of the common law of negligence, shifting the

17 Rogers Whitaker et al, 175 CLR 479; (1992) 109 ALR 625 (1992) P 4
18 Civil Liability Act 2002 (NSW) s 5O; Civil Liability Act 2003 (Qld) s 22; Civil Liability Act 1936 (SA) s 41.

protective bias from injured patients to defendants and insurance companies. If the core purpose of negligence law is to protect patients from harm, this adjustment constitutes a major step backwards[19].

C. Causation: A Persistent Challenge to Patient Protection

Within the legal framework governing medical negligence, when assessing the significance of a given risk, there is no requirement to prove that a patient would have refused treatment if they had been informed of that risk ahead of time. This type of hypothetical patient conduct falls under the causation stage of resolving medical malpractice disputes. The core standard for determining a risk's significance is, applied separately to two groups ordinary reasonable patients and specific individual patients to assess whether the relevant patient would have seriously weighed that risk before making their decision to undergo treatment[20].

The *1998 case Chappel v Hart (case number: 195 CLR 232),* heard by the High Court of Australia, is a typical medical tort case involving insufficient risk disclosure. The plaintiff claimed that if the defendant had informed her of the risk of vocal cord damage, she would have chosen a more experienced surgeon to avoid the harm that actually occurred[21]. The majority of justices ruled that the failure to disclose deprived the plaintiff of the opportunity to avoid that risk, thus establishing causation. This case greatly expanded patient protections in informed consent cases, using the hypothetical scenario of "if informed, the patient would have made a

19 White et al (n 1) 281–283
20 White et al (n 1) 296
21 Chappel v Hart (1998) 195 CLR 232, 243 [27] (McHugh J)

different choice" to concretize the core legal principle centered closely on patient autonomy.

Under the common law system, the balance of probabilities standard used to establish causation has long been criticized by legal practitioners as arbitrary and unfair for its all-or-nothing application outcomes. This criticism is most prominent in loss of chance claims: a plaintiff cannot prove that their harm was directly caused by the defendant's negligence, and can only prove that the defendant's negligence deprived them of the opportunity to achieve a better outcome. Despite these widespread criticisms, the High Court of Australia, in the case of *Tabet v Gett*, still refused to uphold such claims for damages for loss of chance in the field of medical negligence[22].

D. Alternative Redress Mechanisms

The shortcomings of the tort system have created a persistent interest in alternative ways of providing patient redress. These include no-fault compensation schemes, health complaints commissioners and apology legislation[23].

In Victoria, the Health Services Commissioner offers a non-adversarial complaints process which is far more accessible than litigation, as does the Health Care Complaints Commission in NSW[24]. These bodies can lead to systemic positive changes in health care even if they donot get monetary compensation. But they do not offer any monetary

22 Tabet v Gett (2010) 265 ALR 227
23 White et al (n 1) 362-364
24 Health Complaints Commissioner Act 2016 (Vic); Health Care Complaints Act 1993 (NSW).

compensation to patients, and Farrell et al have pointed out that the powers they have vary from jurisdiction to jurisdiction, leading to differing access to redress[25].

Various cases for a no-fault compensation scheme in the New Zealand model have been repeatedly raised in Australia. There is a major omission in the protection of patients who suffer injury due to medical error that is not caused by negligence, and the tort system is structurally unable to address it the New Zealand ACC scheme is able to do this. White et al highlight that political and fiscal barriers have halted progress towards implementing a similar scheme in Australia.

IV. Bioethical Principles: Animating and Critiquing the Law

The core theoretical framework of biomedical ethics originates from the pioneering work Principles of Biomedical Ethics by Beauchamp and Childress. This foundational text in the field organizes basic medical ethics into four prima facie principles: autonomy, beneficence, non-maleficence, and justice[26]. This Part considers how each principles works, and where the law falls short or succeeds in providing the protections each one requires.

A. Autonomy

The principle of autonomy is arguably the most prominent bioethical principle in Australian health law, and is directly operationalized through the doctrine of informed consent, which imposes a duty on the part of the healthcare provider to provide sufficient information for patients to be

25 Anne-Maree Farrell, Sarah Devaney and Amber Dar, 'No-Fault Compensation Schemes for Medical Injury: A Review' [2010] SSRN Electronic Journal.
26 White et al (n 1) 777

able to make informed choices. Respecting an autonomous agent means at least recognizing the individual's right to have opinions, to make decisions, and to act in accordance with values and beliefs. There's more to respect than a respectful attitude, there's respectful action, too. It also demands more than mere noninterference with other people's private life. It contains, at least in some circumstances, a commitment to developing or strengthening others' autonomy to make decisions, as well as a commitment to reducing fears or other circumstances that inhibit or destroy autonomy in action. Respect in this regard means recognizing recognizing decisions made and allowing people to make their own choices, while disrespect for autonomy means attitudes and actions that disregard, demean or insult the rights of autonomy of others. Not all patients and potential subjects are able to provide informed consent. Competence-related questions examine the patient or potential patient's ability, either psychologically or legally, to make decisions. Decision making ability is closely related to independent decision making, and to the validity of consent. Some commentaries make a distinction between competency and capacity, on the basis that health professionals make a capacity judgment and courts make a competency judgment. It was one of the most important moments in the development of health law in Australia when the Bolam standard was rejected as a standard in the context of disclosure of information, a statement of patient autonomy over professional paternalism[27].

27 Tom L Beauchamp and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 6th ed., 2013). P 53-69

B. Beneficence and Non-Maleficence

Within the scope of medical ethics, the two core principles of beneficence and non-maleficence jointly form the core ethical responsibilities for research subjects, requiring that net medical benefits be delivered to them and harm be controlled to the minimum level. Beneficence also gives rise to the obligations to proactively carry out research and participate in professional education and training. The core of non-maleficence is that one must never inflict harm on others, and it is often tied to the Latin maxim "first, do no harm". Yet this maxim, which is widely cited by medical and healthcare staff, has ambiguous origins and its connotations are often poorly defined[28].

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The obligation to do what is beneficial for the patient and the duty not to cause harm to the patient are reflected in the law of medical negligence,

28 RGillon,“MedicalEthics:FourPrinciplesPlusAttentiontoScope”(1995)14 Monash Bioethics Review 25.m
29 White et al (n 1) P 777

which requires practitioners, on pain of liability, to demonstrate “reasonable skill and care” to promote patient welfare and to avoid injury. In this regard, the tort of negligence converts the bioethical responsibility into a legally binding one.

But the post-Ipp civil liability reforms have added in a number of significant restrictions which can be interpreted as a diminished expression of the law's non-maleficence. The reforms indicate a regression, given that the purpose of non-maleficence is to demand positive prevention of harm; the focus on insurance cost and litigation volume is more systemic than is the benefit to patients of being protected from harm[30].

Today, the Hippocratic duty to do good remains as the well known bioethical principle of beneficence and the duty to avoid harm, known as nonmaleficence. One of the features of Ashcroft’s second, bioethical phase has been the challenge to modern medicine’s “technological imperative”, aimed at avoiding treatments predicted to be of little or no benefit and their potential harms. Some have seen this "prudence" of the old doctors as rather than an ethical rule, a rule of prudence in medicine because a doctor's reputation is not improved when he fails often. The systemic governance frameworks national safety standards, accreditation processes and professional regulatory bodies can be seen as institutional expressions of beneficence. In that regard, the regulatory system of the

30 Beauchamp and Childress (n 2) P 165

health system reflects the beneficence more fully than the law of tort is designed to do: it is reactive, not preventive[31].

C. Justice

In relation to health and medical research ethics, the concept of justice was broken down into three moral duties: the duty to distribute scarce resources fairly (distributive justice); the duty to respect research participants' rights (rights-based justice) and the duty to respect morally acceptable laws (legal justice). Distributive justice is fairness and equity in the distribution of resources, rights and responsibilities among members of society in accordance with the recognized rules for social interaction. It covers the allocation of benefits, burdens, property and opportunities. This differs from the notion of criminal justice, where the emphasis is on punishment, and rectificatory justice, which deals with compensation for transactional problems. This type of distribution problem usually occurs in situations of scarcity and competition[32].

There is a vast imbalance in the functioning of the tort system of medical negligence. Many patients from marginalised groups, such as those with disability, those with limited English language skills, and those who are financially disadvantaged, have huge practical difficulties accessing redress for medical harm[33]. If patients are hurt for no fault of the medical professional, they will not benefit from the legal system, even if their injury is serious. This is a huge justice gap.

31 White et al (n 1) P 116
32 Beauchamp and Childress, p 226-239
33 Farrell et al (n 22) ch 2,P 22

Justice is an issue that emerges in the context of consent law about how patients are treated differently depending on their status and vulnerability. The principle of autonomy and bodily integrity which the law professes has not been equally applied to all of the population.[34]

In the adverse medical event disclosure stage of medical malpractice cases, the core value of apologies is becoming increasingly prominent. At present, all jurisdictions across Australia have enacted legislation stipulating that a party's acts of issuing an apology or reducing or waiving medical service fees shall not be deemed an admission of liability, in order to encourage such positive ethical acts. In judicial practice, deductions to awarded damage compensation amounts can offset the difficulty of forecasting future circumstances and implement the principles of compensation assessment. For deductions related to life changes that affect losses of future earning capacity, four factors must be incorporated: the possibility of unemployment, unexpected accidents, the probability of remarriage, and the impact of marriage on earning capacity.[35]

V. Conclusion

Healthcare providers have varying levels of protection from Australian health law. In the realm of consent, the law has advanced a great deal closer to the 'patient-centred' benchmark of Rogers v Whitaker, and to the principle that the patient can refuse even lifesaving treatment. However, when applied to children and persons with disabilities who are seeking gender affirmation care, the principles of protection and restriction

34 Senate Community Affairs Committee (n 15) ch 2
35 White et al (n 1) 351

become conflicted again. Legislation and regulations that claim to safeguard can, in practice, be barriers to patient care.

In the realm of medical error and patient redress, there is a legal remedy, namely the tort of negligence, which is however virtually unavailable to many patients, subject to burdensome causation conditions, and narrowed down by the civil liability reforms of the post-2002 period. The lack of a full-scale no-fault compensation system is one of the areas where patient protection is lacking, and is incompatible with serious respect for the bioethical principle of justice.

The 4 principles of bioethics autonomy, beneficence, non-maleficence and justice offer a useful lens for considering the Australian Health Law. The principles are apparent in the law, but each principle also shows where the law is inadequate. The law of informed consent does not give autonomy to vulnerable populations. Beneficence and non-maleficence are alive in both the duty of care in negligence and the systemic protections for safety, but become muted when implemented in the context of the post-Ipp reforms. The distribution of legal protection and redress is both deeply unequal and the least achieved: this is justice. These shortcomings in institution, judicial development and legislative design must be continuously addressed to ensure genuine protective health law.

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